

blood-corpuscles through the vessels of the choroid. 5. His last variety is the *vascular spectrum*, a term applied to certain fixed muscæ, as those produced in Purkinje's well-known experiment, in which the blood-vessels and central spot of the retina are brought into view, as also the numerous class of phenomena known by the names of *accidental colours* and *ocular spectra*.—*Kirke's Report in Ranking's Abstract*, vol. ii.

56. *Cure of Strabismus.—Ligatures on the Recti Muscles of the Eye.*—DIEFFENBACH appears to have been the first, in 1842, to apply a ligature to the divided end of the muscle for the purpose of rendering the cure of strabismus by operation more perfect. Mr. WILDE, of St. Mark's Ophthalmic Hospital, has been the first to resort to this method extensively in this country. He has employed it in at least eighteen patients, including cases of both convergent and divergent strabismus. When there is reason to believe that division of the tendon will not rectify the deformity, which circumstance may frequently be determined beforehand, the portion of the muscle attached to the sclerotica should be left longer than usual, by dividing it between the hook and its origin, as far back as can be safely managed. Having curved a small sewing-needle, about No. 7, and armed it with a fine ligature, the end of the muscle attached to the sclerotica has to be seized with a fine-toothed forceps, and the thread passed twice through it, drawing it tight the second time, so as to secure firmly a piece of the divided tendon. By this means a power is attained over the globe, which will carry it in any direction. In fixing the ligature, care should be taken to fasten it by a second coil into the muscle; otherwise, if allowed to play in a loop, it will cut through before the object is effected. The loose end of the ligature is to be attached, by means of adhesive straps, to the middle of the nose, or to the malar bone, so as to draw the globe of the eye in the direction required. The length of time it must remain on varies according to circumstances, but, as a rule, it should never be removed while it continues on the stretch, or in other words, till the eye has completely righted itself, either by the action of the other muscles, or by the fixed position, "the setting," of the globe in its new aspect. The patient appears to experience but little inconvenience. In some instances the ligatures have been applied to both eyes, and Mr. Wilde suggests that a ligature might be tied without dividing the muscle where strabismus is caused by permanent spasm, or shortening of the internal rectus, or paralysis of the abductor, and also for the purpose of restoring to a straight position those eyes that have become over-divergent after the usual operation.—*Ancell's Report*, from *Dublin Journal*, Nov., 1845.

MIDWIFERY.

57. *Two cases of Labour protracted by Insuperable Rigidity of the Os Uteri—with remarks.* By JOHN C. LEVER, M.D. (*Guy's Hospital Reports*, Oct., 1145).—In this interesting paper the author gives the history of two cases of labour protracted by insuperable rigidity of the os uteri. In the first case, which the author saw in consultation with Mr. Dry, various remedies were tried without overcoming the rigidity; and a portion of the os and cervix of the uterus was separated during labour and expelled. The patient died. The second case Dr. Lever saw in consultation with Mr. Evans. He divided the whip-cord margin of the os uteri towards the posterior part of the sides of the pelvis, in the direction of either sacro-iliac sychondrosis. The incisions were made during the contraction of the uterus and gave no pain. The labour then went on and terminated favourably.

In his remarks Dr. Lever refers to other cases of a similar character, and concludes with the following propositions:—

1st. That insuperable rigidity of the os uteri occasionally occurs, over which the usual remedies exercise no influence.

2. That such insuperable rigidity may lead to a partial or complete separation of the cervix.

3. That, to prevent such a serious lesion, two methods of treatment have been recommended; the one consisting in artificial dilatation; the other, in incising the rigid and contracted os uteri.

4. That artificial dilatation, in most cases, is unjustifiable, from the serious injuries it occasions, and the consequent irritation and inflammation.

5. That under such circumstances, an incision of the os uteri, in one or more places, should be performed.

6. That the operation is unattended with danger, unaccompanied by pain, and, if rightly performed, free from copious or dangerous hemorrhage.

7. But the operation, to be successful, must be performed before there are symptoms of approaching collapse.

58. *On the Development of the Placenta within the Fallopian Tube.* By J. M. PAGAN, M.D., Prof. Midwifery, University of Glasgow. (*Monthly Journal of Med. Sci.*, Nov., 1845.)—The object of this paper is to direct attention to the development of the placenta, either partially or entirely within the tube. This subject, Prof. Pagan remarks, “has not hitherto received much illustration from accoucheurs; it is left altogether unnoticed in our systematic works on midwifery; and I believe, though I have not entered into any extensive research, that Riecke and D’Outrepoint are the only writers who have directed the attention of the profession to this subject as one of practical importance, giving rise, as they believe, to abortion in the early periods of gestation, and to retention of the placenta in the last stage of labour, frequently mistaken for one or other of the varieties of irregular uterine contraction. Whether the development of the whole, or a part of the placenta within the Fallopian tube, be a frequent occurrence, giving rise to abortion in the first place, and to retention of the placenta in the second, may be questioned; yet, that it does occur occasionally is beyond doubt.”

With reference to the diagnosis of the placenta within the tube before or during labour, Prof. P. says he has nothing to offer, except that he should hope to derive some assistance from auscultation, if he discovered a well-defined tumour of the uterus in the situation of the uterine extremity of either tube. The discovery of this cause of retention of the placenta after the birth of the child, is the most important point, because, if not detected, and treated in the proper manner, it may give rise to hemorrhage, and to the fatal result which frequently ensues upon the retention of a portion of the after-birth; and this cause may be suspected, if the uterus be pretty equally contracted, assuming nearly its natural figure, with the exception of a well-defined soft tumour in the situation of the uterine extremity of either tube. It is true there may be a tumour within the walls of the uterus itself, which, in some cases, Prof. F. has known to increase with the enlargement of the uterus during gestation, and gradually to diminish, probably to the size which it had attained before pregnancy ensued. Yet he thinks the two conditions may be distinguished. It is, however, unnecessary to enter into this point, because it is obvious that if the development of the placenta within the tube should occasion hemorrhage, or prove a cause of retention, it would lead to the usual practice in such cases and to the discovery of the cause. It is not certain that the placenta may not be wholly, or partially developed in the Fallopian tube, though we do not discover it, because the muscularity of the tube increases with its expansion; and unless there should be preternatural adhesion, or irregular contraction, particularly of its sphincter fibres, the tube itself is capable of separating the placenta from its attachment, and expelling it by its contractility, into the cavity of the uterus.

Prof. P. describes the only case which has occurred to himself where he was certain that a portion of the placenta was developed within the tube, and where it gave rise to retention and secondary hemorrhage. We shall not give the particulars of this case, but subjoin those of a very interesting one communicated to the Prof. by Mr. J. Bell, in which a post-mortem examination was made.

“The case, of which the following account is a summary, occurred in the practice of my late partner, Mr. Hunter, January 3, 1838. Mrs. M'D., after a tedious labour, gave birth to a male child. About an hour afterwards, considerable hemorrhage took place, and though cold in the usual modes was assiduously applied, yet the flooding increased. Mr. H. determined to remove the placenta, and was in the act of introducing his hand for that purpose, when the woman fainted. The relatives becoming alarmed, I was sent for. I found the patient pale and much exhausted, the loss of blood somewhat diminished, and the pla-